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Research Article

MODERN ASPECTS OF SURGICAL TREATMENT OF ACUTE AND CHRONIC PARAPROCTITIS

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ABSTRACT

Results of surgical treatment of patients with acute and chronic paraproctitis. These results suggest that the choice of the optimal amount and method of surgical intervention in acute paraproctitis and rectal fistula is crucial in preventing relapses and complications, and ensuring a favorable outcome in the long term. A differentiated approach to the choice of surgical intervention in patients with acute and chronic paraproctitis improves both immediate and long-term outcomes of patients in this category

KEYWORDS

Acute abscess, rectal fistula, surgery.

INTRODUCTION

Paraproctitis is one of the most frequent diseases in proctological practice. Diagnostic and treatment issues of this disease are constantly discussed in the Russian and foreign press, however, they are still not

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completely solved and often become a subject of discussions. According to data of leading clinics in our country and abroad patients with acute paraproctitis make up 0,5-4% among patients with general surgical pathology and 20-40% in the structure of proctologic diseases. Patients with chronic paraproctitis comprise 0.5-4% of all surgical inpatients and 30-35% of patients with rectal diseases [1,5,8,9,13,24].

The lack of familiarity of surgeons with this pathology leads to a large number of unsatisfactory outcomes. Many patients with acute paraproctitis do not always receive timely and qualified care, undergo prolonged treatment, and are out of active employment for a long time[2,3,6,10,11]. As a result of long-term purulent process in perianal region a cicatricial deformity of perineum with anal sphincter insufficiency develops that often leads to permanent disability of patients [4,7,12,23]. To date, the percentage of unsatisfactory treatment results is still quite high. In 13-20% of patients operated on for acute paraproctitis, there are pyoinflammatory complications in the wound, in 4-10% of patients the disease relapses or develops into a chronic course, in 6-8% of patients there is anal sphincter deficiency and in 17-36% of operated patients there is discomfort in the anus [14,15,17,20,25].

According to most researchers, after surgical treatment of rectal fistulas, suppuration of the postoperative wound occurs in 10-13% of patients, recurrence of the disease in 1.5-10.2% of operated patients and anal sphincter failure in 1.5-27.9% of patients [16,18,19,21,22]. After surgical intervention for intra- and transsphincter fistulas, anal discomfort occurred in 1.8-22.4% of patients [1,8,10,19,24].

The prevalence and frequency of this pathology, especially in persons of working age, unsatisfactory immediate and long-term outcomes of the disease motivate researchers to search for new, most modern approaches aimed at improving the results of paraproctitis treatment.

PURPOSE OF THE STUDY

To develop a set of diagnostic, tactical and therapeutic measures aimed at improving the treatment outcome of acute and chronic paraproctitis.

MATERIALS AND METHODS

866 patients with acute and chronic paraproctitis were treated in the proctology department of SamMI Clinic No.1 2016- 2022.We carried out retrospective analysis of treatment of 866 patients (men 601 (69.3%); women 265 (30.7%)). Age:20-40 years old - 314 (36,2%), 40-60 years old - 301 (34,7%), 60 and more - 35 (4,0%).

The operation for acute paraproctitis was carried out in 650 patients. Localization of purulent processes in pararectal cage: acute subcutaneous paraproctitis -327 (50,3%); acute submucosal paraproctitis - 76 (11,6%); acute ischiorectal paraproctitis - 204 (31,3%); acute palviorectal paraproctitis - 29 (4,6%); acute retrorectal paraproctitis - 3 (0,4%); anaerobic paraproctitis - 11 (1,8%). Diabetes mellitus was observed in 21 (3.2%) patients.

The diagnosis of acute paraproctitis was based on the anamnesis, clinical picture, and objective examination of patients. Preoperative period included examination, palpation of perianal area, finger examination of rectum, laboratory, X-ray, ultrasound, bacteriological examination of patients.

Treatment of patients with acute paraproctitis presents a complex and difficult task which includes radical sanation of purulent focus, liquidation of distant consequences of the pathological process, prevention of recurrence of the disease.

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Rectal fistula is an inflammatory process in anal crypt, intersphincter space and pararectal tissue with formation of fistulous passage. Patients with this pathology account for about 216 (25%) of all proctologic patients (1, 2).

Extrasphincteric fistulas are classified according to their degree of complexity. In the first degree of extra-sphincteric fistula complexity, the internal orifice is narrow without scarring around it, there are no pustules or infiltrates in the tissue, and the course is fairly straight. In grade 2, there is scarring around the internal orifice, but no inflammatory changes in the tissue. In third-degree extra-sphincteric fistulas, there is a narrow inner orifice without scarring around it, but there is purulent inflammation in the tissue. In the fourth degree, they have a wide internal orifice surrounded by scarring, with inflammatory infiltrates or purulent cavities in the cellular spaces.

In transfincter and extrasphincter fistulas, fistulography and assessment of anal sphincter function must complement the examination.

The most common types of operations for rectal fistulas are excision of the fistula into the rectal lumen;excision of the fistula into the rectal lumen (Gabriel operation);excision of the fistula into the rectal lumen with opening and drainage of the leak;excision of the fistula into the rectal lumen with sphincter suturing;excision of the fistula with ligature;excision of the fistula with relocation of mucosa or muco-muscular flap of the distal rectus to liquidate the internal fistula opening [3].

The greatest problem is the treatment of extrasphincteric fistulas, with recurrences of 6-10%.

In the preoperative period, laboratory, radiological, endoscopic and bacteriological examination was performed. The choice of the optimal volume and method of surgical intervention for acute paraproctitis is crucial in preventing recurrences and complications and ensuring a favourable outcome in the long term.

Surgical interventions were carried out under peridural or spinal anesthesia.

At subcutaneous and submucosal forms of paraproctitis an abscess was opened in the lumen of rectum according to Gabriel method in 285 patients (43,8%). At ischiorectal and pelviorectal forms of paraproctitis two-stage surgical tactics was used. At the acute stage of the disease a dissection, sanation and drainage of the abscess was carried out.

Necrectomy with a wide opening of purulent abscesses was applied in patients with anaerobic forms of paraproctitis characterized by extensive purulent-necrotic affection of pararectal cellular tissue and a severe clinical course.

In the postoperative period intensive antibacterial, infusion therapy was carried out. Antibiotics were used according to the sensitivity of the microflora.

When pararectal fistulas were formed, a radical operation was performed - excision of the purulent passage with elimination of the internal orifice of the fistula. After opening of the pararectal fistula without liquidation of the internal opening of the paraproctitis, the recurrence of the disease or rectal fistula occurred in 70-100% of cases.

At a choice of operative intervention it was taken into account: relation of fistulous passage and internal orifice to sphincter; presence of cicatricial process along fistula; presence of infiltrates and purulent sinkholes in pararectal cellulose.

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For rectal fistulas 216 operations were done, intrasphincteric fistulas - 64 (30,5%), transphincteric - 96 (44,5%), extrasphincteric - 56 (25,0%).

In intrasphincteric fistulas the following operations were performed: excision of the fistula into the intestinal lumen with suturing of the wound bed. There were no suppuration of wounds, recurrences, or insufficiency of the anal bridge. Transsphincter fistulas were treated by excision of the fistula with suturing of part of the external sphincter and ligature method. Inflammation of the wound occurred in 3 patients (3.1%), recurrence in 8 (8.3%) and anal fistula failure in 2 (2.0%).

In extrasphincter fistulas we performed excision of fistula and ligature method, excision of fistula with relocation of mucosal flap. There was wound suppuration in 2 patients (3.5%), recurrences in 3 (5.3%), insufficiency of anal bridge in 1 (1.7%). The average duration of inpatient treatment was 8 bed-days. The total duration of temporary incapacity for work was 23 days.

CONCLUSIONS

the differentiated approach to the choice of operative intervention, optimization of preoperative preparation and postoperative treatment of patients with acute paraproctitis makes it possible to improve both the nearest and distant treatment results of patients of this category, to reduce terms of treatment and temporary disability, the number of complications and recurrences.

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